AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO:

PATIENT NAME: Keith D. Sewell

CA04-85E

BIRTH DATE:

RELEASE TO: Lee J. Karl, AUSA
U.S.P.O. & Courthouse
700 Grant Street, Suite 400
Pittsburgh, PA 15219

INFORMATION REQUESTED: I request and authorize the above-named person or class of persons to release information specified below to representatives of the United States Attorney's Office or the Department of Justice. Any and all records regarding treatment of **Keith D. Sewell** including but not limited to:

1. Copy of complete chart, progress notes & interview notes, discharge summaries, operative reports, x-ray & all imagery, laboratory tests, pathology tissue, and all diagnostic studies whether in electronic data or other format.

2. Billing records.

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:
(Include case name or identify administrative claim.)

Sewell v. USA, Civil Action No. 04-085E

CERTIFICATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, provided that revocation is in writing, except to the extent that action has already been taken in reliance this Authorization. I understand that the doctor, health care provider, or health plan from whom my medical information is requested in this Authorization, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. I understand and potential for the information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no long be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth in 45 CFR Parts 160 and 164.

EXPIRATION:
(Check One)

__X__ This Authorization will automatically expire upon completion of the litigation Sewell v. USA now pending in U.S. District Court for the Western District of Pennsylvania.

_____ This Authorization will automatically expire upon completion of the administrative claim of _____ filed on _____.

_____ This Authorization shall be effective until _____.

OTHER CONDITIONS:

__x__ A copy of this Authorization or my signature thereon shall be used with the same effectiveness as an original.

__x__ Communications between provider and any representative of the U.S. Attorney's Office/Department of Justice are authorized.

SIGNATURE OF PATIENT: Keith Sewell

OR PERSON AUTHORIZED TO SIGN FOR PATIENT:* _____

8-17-05
MONTH/DAY/YEAR

Keith Sewell
PRINT OR TYPE NAME

*Provide basis of Authorization:_____